		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011551

Facility Name: Medina Nursing Center

Address: P.O. Box 538 (Number) Durand (City) 61024 (Zip Code)

County: Winnebago

Telephone Number: (815) 248-2151 **Fax #** (815)248-2771

IDPA ID Number: 366125769001

Date of Initial License for Current Owners: 05/18/65

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** 312-634-4580
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	89	Skilled (SNF)	89	32,574	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,574	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	248	18	784	1,050	8
9	SNF/PED					9
10	ICF	18,217	6,972		25,189	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,465	6,990	784	26,239	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.55%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 12 and days of care provided 784

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	A. General Services											
1	Dietary	174,849	14,138	4,474	193,461		193,461		193,461			1
2	Food Purchase		184,624		184,624		184,624	(11,164)	173,460			2
3	Housekeeping	66,600	21,873		88,473		88,473		88,473			3
4	Laundry	61,779	10,059		71,838		71,838	(2,326)	69,512			4
5	Heat and Other Utilities			55,452	55,452		55,452		55,452			5
6	Maintenance	40,940	11,848	28,776	81,564		81,564		81,564			6
7	Other (specify):*											7
8	**TOTAL General Services**	344,168	242,542	88,702	675,412		675,412	(13,490)	661,922			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	729,017	27,495	254,868	1,011,380		1,011,380	2,326	1,013,706			10
10a	Therapy		806	53,812	54,618		54,618		54,618			10a
11	Activities	31,442	2,167	9,306	42,915		42,915		42,915			11
12	Social Services	48,430		1,583	50,013		50,013		50,013			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	808,889	30,468	325,569	1,164,926		1,164,926	2,326	1,167,252			16
	C. General Administration											
17	Administrative	144,571			144,571		144,571		144,571			17
18	Directors Fees											18
19	Professional Services			29,678	29,678		29,678	(33)	29,645			19
20	Dues, Fees, Subscriptions & Promotions			11,529	11,529		11,529	384	11,913			20
21	Clerical & General Office Expenses	60,859	13,371	15,688	89,918		89,918		89,918			21
22	Employee Benefits & Payroll Taxes			209,279	209,279		209,279	(384)	208,895			22
23	Inservice Training & Education			1,736	1,736		1,736		1,736			23
24	Travel and Seminar			2,580	2,580		2,580	(43)	2,537			24
25	Other Admin. Staff Transportation			3,590	3,590		3,590		3,590			25
26	Insurance-Prop.Liab.Malpractice			14,549	14,549		14,549		14,549			26
27	Other (specify):*											27
28	**TOTAL General Administration**	205,430	13,371	288,629	507,430		507,430	(76)	507,354			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,358,487	286,381	702,900	2,347,768		2,347,768	(11,240)	2,336,528			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Medina Nursing Center #0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			79,013	79,013		79,013	4,411	83,424			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,068	4,068		4,068	5,996	10,064			32
33	Real Estate Taxes			30,869	30,869		30,869		30,869			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(36,000)				34
35	Rent-Equipment & Vehicles			18,480	18,480		18,480		18,480			35
36	Other (specify):*											36
37	**TOTAL Ownership**			168,430	168,430		168,430	(25,593)	142,837			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,665	3,217	33,882		33,882		33,882			39
40	Barber and Beauty Shops	8,627	339		8,966		8,966		8,966			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,862	48,862		48,862		48,862			42
43	Other (specify):* **Nonallowable costs**			47,723	47,723		47,723	(47,723)				43
44	**TOTAL Special Cost Centers**	8,627	31,004	99,802	139,433		139,433	(47,723)	91,710			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,367,114	317,385	971,132	2,655,631		2,655,631	(84,556)	2,571,075			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,164)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,603)	30		9
10	Interest and Other Investment Income	(1,584)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(43)	24		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,635)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,531)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(534)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(29,356)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (77,450)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(7,106)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (7,106)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (84,556)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center, Inc.
Provider # 0011551
December 31/2000

Page 5 **Schedule 5A**

Schedule VI.- Adjustment Detail
Line 29, Other Non-Allowable Expenses

Description	**Amount**	**Sch V line reference**
Vending Machine Supply	(8,951)	43
Laboratory Expense	(19,306)	43
Out of period Legal Expense	(1,333)	19
Insurance	234	43
	(29,356)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Medina Nursing Center

ID# 0011551

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
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72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Holgeir J. Oksnevad**	100.00%			Medina Manor Building, Inc.	Durand	Lessor
**Son of Johs Oksnevad, owner of Medina Manor Building, Inc.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting Fees	$	Medina Manor Building, Inc.	0.00%	$ 1,300	$ 1,300	1
2	V	30	Depreciation		Medina Manor Building, Inc.	0.00%	20,014	20,014	2
3	V	32	Interest		Medina Manor Building, Inc.	0.00%	7,580	7,580	3
4	V	34	Rent Income	36,000	Medina Manor Building, Inc.	0.00%		(36,000)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 36,000			$ 28,894	$ * (7,106)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Holgeir Oksnevad	President	Administrator	100.00%	None	55	100.00	Salary	$ 144,571	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 144,571		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11					N/A					11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	State Bank of Davis		x	Bus Loan	$816.00	06/15/98	$ 40,200	$ 18,209	06/15/03	0.0825	$ 2,171	1
2	State Bank of Davis		x	Auto Loan	$781.00	02/26/99	25,020	8,875	02/26/02	0.0775	1,157	2
3	State Bank of Davis		x	Auto Loan	$919.00	07/25/00	22,065	21,550	07/25/02	0.0925	740	3
4												4
5												5
	Working Capital											
6	Unsecured notes allocated from	x		Working Capital	None	Various	Various	68,158	Demand	0.0700	7,580	6
7	Medina Manor Building											7
8	Holgeir Oksnevad	x		Working Capital	None	Various	Various	45,000	Demand	none		8
9	TOTAL Facility Related				$2,516.00		$ 87,285	$ 161,792			$ 11,648	9
	B. Non-Facility Related*											
10									Interest Income Offset		(1,584)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,584)	14
15	TOTALS (line 9+line14)						$ 87,285	$ 161,792			$ 10,064	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 34,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 31,869	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,131)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 33,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 30,869	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:						
1995	27,305	8	1999 Tax	31,869		**FOR OHF USE ONLY**
1996	31,170	9	Estimated Tax Increase	1.04		
1997	33,224	10		33,144	13	FROM R. E. TAX STATEMENT FOR 1999 $ 13
1998	32,672	11	use	33,000	14	PLUS APPEAL COST FROM LINE 5 $ 14
1999	31,869	12			15	LESS REFUND FROM LINE 6 $ 15
					16	AMOUNT TO USE FOR RATE CALCULATION $ 16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,000 B. General Construction Type: Exterior Brick Frame Masonry, Fire Resist Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Medina Manor Apartments
-Retirement Apartments
-22 units
-20,000 Sq. ft

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	resident care	7 acres	1965	$ 3,048	1
2					2
3	TOTALS			$ 3,048	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1965	1965	$ 488,644	$	30	$	$	$ 488,644	4
5	25		1980	1980	158,172		30	5,272	5,272	110,873	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1968	675		15			675	9
10	Building Improvements			1974	861		10			861	10
11	Building Improvements			1975	1,547		10			1,547	11
12	Building Improvements			1976	345		9			345	12
13	Building Improvements			1977	12,614		21			12,614	13
14	Building Improvements			1977	2,793		8			2,793	14
15	Building Improvements			1979	2,620		7			2,620	15
16	Building Improvements			1980	24,465		20	612	612	24,465	16
17	Building Improvements			1980	2,137		7			2,137	17
18	Building Improvements			1981	20,211		15			20,211	18
19	Building Improvements			1982	2,305		20	115	115	2,186	19
20	Building Improvements			1983	705		5			705	20
21	Building Improvements			1985	980		10			980	21
22	Building Improvements			1985	3,091	104	20	155	51	2,399	22
23	Building Improvements			1986	17,543		10			17,543	23
24	Building Improvements			1987	56,373	3,758	20	2,819	(939)	38,047	24
25	Building Improvements			1988	14,212	947	20	711	(236)	8,880	25
26	Building Improvements			1989	30,063	2,004	20	1,503	(501)	17,285	26
27	Building Improvements			1990	1,603	107	20	85	(22)	844	27
28	Building Improvements			1991	51,619	3,441	20	2,581	(860)	24,519	28
29	Building Improvements			1991	11,626		20	581	581	4,941	29
30	Building Improvements			1992	39,070	2,605	20	1,954	(651)	14,653	30
31	Building Improvements			1992	3,295	203	20	165	(38)	1,401	31
32	Building Improvements			1992	19,372		20	969	969	8,234	32
33	Building Improvements			1992	23,809	2,362	20	1,190	(1,172)	10,115	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 990,750	$ 15,531		$ 18,712	$ 3,181	$ 820,517	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1993	37,059	2,471	20	1,848	(623)	13,898	9
10	Building Improvements			1993	100,000		20	5,000	5,000	36,667	10
11	Building Improvements			1994	53,900	3,216	20	2,695	(521)	17,517	11
12	Building Improvements			1994	15,610		10	1,561	1,561	10,146	12
13	Building Improvements			1995	47,826	3,188	15	3,188		17,535	13
14	Building Improvements			1995	36,144	2,410	15	2,410		13,254	14
15	Outdoor Signs			1996	2,149	143	15	143		644	15
16	Backflow Preventors			1996	3,679	245	15	245		1,103	16
17	Garbage Disposal			1996	761	51	15	51		229	17
18	Custom Therapy Cabinets			1997	2,532	169	15	169		591	18
19	Door			1997	1,996	133	15	133		466	19
20	Sign			1997	666	44	15	44		155	20
21	Air Conditioner			1997	3,500	233	15	233		816	21
22	Lights			1997	621	41	15	41		144	22
23	Driveway			1997	2,875	192	15	192		672	23
24	Fire Alarm			1997	1,246	83	15	83		291	24
25	Plumbing			1997	5,122	341	15	341		1,194	25
26	Telephone System			1997	1,152	77	15	77		245	26
27	Permanent Outdoor Receptacles			1997	585	39	15	39		137	27
28	Office Remodeling			1998	2,454	164	15	164		410	28
29	Exterior Doors			1998	7,652	510	15	510		1,275	29
30	Windows			1998	15,536	1,036	15	1,036		2,590	30
31	Roof Repair			1998	2,317	154	15	154		385	31
32	Water and Sewer Improvements			1998	3,165	211	15	211		526	32
33	Fire Alarm			1998	1,157	77	15	77		193	33
34	Telephone System			1998	1,467	98	15	98		243	34
35	Time Clock System			1998	8,238	549	15	549		1,374	35
36	TOTAL (lines 4 thru 35)				$ 359,409	$ 15,875		$ 21,292	$ 5,417	$ 122,700	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Blinds			1999	3,689	246	15	246		368	9
10	Window Replacement			1999	5,145	305	15	343	38	515	10
11	Rewire & Replumb Laundry Room			1999	7,824	481	15	521	40	782	11
12	Floor Tile			1999	1,049	70	15	70		105	12
13	Air Conditioning			1999	1,895	126	15	126		189	13
14	Boiler			1999	535	35	15	35		53	14
15	Sidewalk			2000	1,386	46	15	46		46	15
16	Kickplates			2000	608	20	15	20		20	16
17	Landscaping Brick			2000	1,139	38	15	38		38	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 23,270	$ 1,367		$ 1,445	$ 78	$ 2,116	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 212,179	$ 24,823	$ 20,558	$ (4,265)	10 Years	$ 121,134	37
38	Current Year Purchases							38
39	Fully Depreciated Assets	218,104				10 Years	218,104	39
40								40
41	TOTALS	$ 430,283	$ 24,823	$ 20,558	$ (4,265)		$ 339,238	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Activity Bus	1975 Ford Bus	1985	$ 9,409	$	$	$	3	$ 9,409	42
43	Resident Van	1991 Chevy Lumina	1991	18,008				3	18,008	43
44	Activity Bus	1998 Ford Bus	1998	49,705	9,941	9,941		5	34,793	44
45	From Page 13A			69,220	11,476	11,476		5	34,233	45
46	TOTALS			$ 146,342	$ 21,417	$ 21,417	$		$ 96,443	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,953,102	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 79,013	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 83,424	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 4,411	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,381,014	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$	$	$	$ 0		$	37
38	Current Year Purchases				0			38
39	Fully Depreciated Assets				0			39
40					0			40
41	TOTALS	$ 0	$ 0	$ 0	$ 0		$ 0	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Administrative	1999 Lexus SUV	1998	45,515	$ 9,104	$ 9,104	$ 0	5	$ 31,861	42
43	Maintenance	1997 Dodge Pickup	2000	23,705	2,372	2,372	0	5	2,372	43
44							0			44
45							0			45
46	TOTALS			$ 69,220	$ 11,476	$ 11,476	$ 0		$ 34,233	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	1998 BMW	$ 1,290.51	$ 15,487	17
18	Maintenance	1997 Dodge 3500 Pickup	658.59	2,993	18
19					19
20					20
21	TOTAL		$ 1,949.10	$ 18,480	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C3	hrs	$	759	$ 41,889	$	759	$ 41,889	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		42	1,307		42	1,307	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C2&3	hrs		624	10,616	806	624	11,422	4
5	Physician Care		visits							5
6	Dental Care	L39C3	visits				3,070		3,070	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescrpts				30,665		30,665	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Rehabilitation Other (specify): Med A Expense	L39,C3 L39,C3					61 86		61 86	13
14	TOTAL			$	1,425	$ 53,812	$ 34,688	1,425	$ 88,500	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,792	$ 27,792	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	306,374	306,374	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,092	33,092	6
7	Other Prepaid Expenses	41,689	42,923	7
8	Accounts Receivable (owners or related parties)	7,230	7,230	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 416,177	$ 417,411	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,816	14
15	Leasehold Improvements, at Historical Cost	516,495	726,613	15
16	Equipment, at Historical Cost	611,744	576,625	16
17	Accumulated Depreciation (book methods)	(731,963)	(1,381,014)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Life Insurance Cash Value	39,290	39,290	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 435,566	$ 611,378	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 851,743	$ 1,028,789	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 17,014	$ 17,014	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,098	64,844	28
29	Short-Term Notes Payable	44,650	113,158	29
30	Accrued Salaries Payable	70,095	70,095	30
31	Accrued Taxes Payable (excluding real estate taxes)	589	589	31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,000	33,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	19,376	19,376	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 249,822	$ 318,076	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	48,634	48,634	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 48,634	$ 48,634	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 298,456	$ 366,710	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 553,287	$ 662,079	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 851,743	$ 1,028,789	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Medina Nursing Center, Inc.
Provider # 0011551
December 31/2000

Page 17 **Schedule 17A**
Schedule XV.
Balance Sheet

Line 36- Other Current Liabilities

	Column 1 Operating	Column 2 After Consolidation
Miscellaneous Current Liabilities	1,281	1,281
Due to Related Party	3,095	3,095
Due to Apartments	15,000	15,000
Total	19,376	19,376

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 681,967	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 681,967	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(11,143)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(117,537)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (128,680)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 553,287	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,422,379	1
2	Discounts and Allowances for all Levels	19,896	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,442,275	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	68,675	6
7	Oxygen	1,371	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 70,046	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,033	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,887	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,031	19
20	Radiology and X-Ray		20
21	Other Medical Services	67,840	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 106,791	23
	D. Non-Operating Revenue		
24	Contributions	219	24
25	Interest and Other Investment Income***	1,584	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,803	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Schedule 19A	23,573	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 23,573	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,644,488	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	675,412	31
32	Health Care	1,164,926	32
33	General Administration	507,430	33
	B. Capital Expense		
34	Ownership	168,430	34
	C. Ancillary Expense		
35	Special Cost Centers	90,571	35
36	Provider Participation Fee	48,862	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,655,631	40
41	**Income before Income Taxes (line 30 minus line 40)****	(11,143)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (11,143)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Medina Nursing Center, Inc.
Provider # 0011551
December 31,2000

Page 19 **Schedule 19A**
Schedule XVII
Income Statement

Line 28a-Other Revenue (specify):

	Amount
Vending Machine Income	9,016
Uniform Income	3,118
Miscellaneous Income	275
Food Purchased	6,073
Meal Sales	5,091
Total	23,573

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,040	2,080	$ 42,337	$ 20.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,651	7,133	122,899	17.23	3
4	Licensed Practical Nurses	8,591	9,551	139,643	14.62	4
5	Nurse Aides & Orderlies	38,300	39,713	364,130	9.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,643	1,833	16,339	8.91	9
10	Activity Assistants	2,117	2,223	15,103	6.79	10
11	Social Service Workers	3,860	4,134	48,430	11.72	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,008	25,067	12.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,047	21,267	149,782	7.04	15
16	Dishwashers					16
17	Maintenance Workers	4,925	5,086	40,940	8.05	17
18	Housekeepers	7,297	7,945	66,600	8.38	18
19	Laundry	7,271	7,739	61,779	7.98	19
20	Administrator	2,710	2,860	144,571	50.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,779	6,133	60,859	9.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,050	2,226	21,192	9.52	31
32	Care Plan Coordinator	2,016	2,260	38,816	17.18	32
33	Other(specify) Barber & Beauty	860	944	8,627	9.14	33
34	TOTAL (lines 1 - 33)	118,117	125,135	$ 1,367,114 *	$ 10.93	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	99	$ 4,474	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	883	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	30	1,583	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	129	$ 12,940		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	103	$ 3,674	L10, C3	50
51	Licensed Practical Nurses	930	31,226	L10, C3	51
52	Nurse Aides	12,387	219,085	L10, C3	52
53	TOTAL (lines 50 - 52)	13,420	$ 253,985		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Holgeir Oksnevad	Administrator	100.00%	$ 144,571
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 144,571

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 1,641
American Express Tax & Business Services	Accounting	7,166
Duane, Morris, & Heckscher	Legal	5,505
Holleb & Coff	Legal	1,332
Achieve Software	Computer	11,963
Mutual of Omaha	Computer	247
Aero Internet Service	Computer	215
Information Control	Computer	1,056
Miscellaneous	Computer	553
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 29,678

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,216
Unemployment Compensation Insurance	9,123
FICA Taxes	100,090
Employee Health Insurance	38,799
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	3,245
401(k) Plan	156
Employee Education	3,397
Employee Goodwill	6,404
Uniforms	3,465
TOTAL (agree to Schedule V, line 22, col.8)	$ 208,895

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	6,438
Health Care Worker Background Check (Indicate # of checks performed 32)	384
Illinois Health Care Association	3,373
Vehicle License	353
Subscriptions & Publications	735
Miscellaneous License	230
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,913

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,070
Less: Non-allowable PAC	(43)
Seminar Expense	510
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,537

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center, Inc.
Provider # 0011551
December 31/2000

Page 21 **Schedule 21A**
Schedule XIX
C. Professional Services

Total (agrees to Schedule V, line 19, column 3)	29,678.00
Allocated from Medina Manor Building, Inc.	1,300.00
Non Allowable Legal Expense	(1,333.00)
Total (agrees to Schedule V, line 19, column 8)	**29,645.00**

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association-$3,373**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **N/A**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,326** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **48,862**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **11,164**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.